



**INFANT FORMULA MANUFACTURERS
ASSOCIATION OF AUSTRALIA, INC**

**Supplementary submission to the House of
Representatives Standing Committee on Health and
Ageing**

Inquiry into the health benefits of breastfeeding

Background

The Infant Formula Manufacturers Association of Australia (IFMAA) made a submission to the inquiry into the health benefits of breastfeeding on 9th March 2007. IFMAA's submission was based on the Inquiry's terms of reference and did not include matters outside these terms of reference.

However it is apparent that both the Advisory Panel for Marketing in Australia of Infant Formula (APMAIF) submission and many other submissions and presentations to the Inquiry refer to matters outside its terms of reference.

These matters include retailer activity, toddler milk and bottles and teats. While they are not part of the terms of reference for this inquiry it appears that some advocates believe that they should be included in the agreement about the Marketing in Australia of Infant Formula (MAIF Agreement).

As advised on 9th March 2007 this supplementary submission is being made to present IFMAA's views on toddler milk and its relationship to the MAIF Agreement.

Introduction

IFMAA represents the five major companies: Heinz, Nutricia, Nestlé, Wyeth and Bayer: manufacturing, importing and marketing their own brands of infant formulas in Australia. IFMAA members are all signatories to the MAIF (Marketing in Australia of Infant Formulas) Agreement.

IFMAA believes that breast milk provides ideal and unequalled nutrition for infants and that self-regulation of the marketing of formula by industry through the MAIF Agreement is working.

Since its introduction the annual number of breaches of the MAIF Agreement has significantly decreased over time reflecting compliance by participating companies. In fact in the past 6 years of the hundreds of complaints received only 3 have been upheld

Some IFMAA members and other food manufacturers also produce toddler supplementary milk products. However they are not breast-milk substitutes and do not compete with breast milk.

Toddler milk was developed in response to the growing evidence of a high incidence of iron deficiency in toddlers, in some cases up to 30%. Toddler milk is an enriched milk drink for young children and is not suitable for children under the age of 12 months. It is designed and marketed to complement toddlers' diets in cases where they may be receiving insufficient nutrients, particularly iron, that are critical for their development.

The WHO Code

The World Health Organisation (WHO) adopted the International Code of Marketing of Breast-milk Substitutes in 1981 with the aim to contribute

“to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.” (Article 1).

The Who Code promotes exclusive breastfeeding for six months followed by continued breastfeeding with appropriate complementary foods up to two years and beyond.

The Code covers products for the first 6 months of life that are suitable for use as a partial or total replacement of breast milk. The global recommendation is exclusive breastfeeding for six months and any food or drink promoted to be suitable for feeding a baby during this period is a breast-milk substitute and thus covered by the Code.

Annex 3 of the WHO Code specifies that the WHO Code's provisions concerning limitations on advertising and other promotional activities do not apply to “other milk products such as complementary foods, food and beverages, etc” so long as the manufacturers and distributors of these products do not promote them as being suitable for use as partial or total replacements for breast milk – refer attached Appendix 1.

Toddler milk products are a complementary food, not a breast milk substitute and their promotion is therefore outside the scope of the WHO Code.

The MAIF Agreement and FSANZ.

While the WHO Code covers formula for infants up to six months of age the Marketing in Australia of Infant Formulas (MAIF) Agreement applies to both infant- and follow-on formula.

Food Standards Australia New Zealand (FSANZ) defines 'Follow-on formula' as: *An infant formula product represented as either a breast-milk substitute or replacement for infant formula which constitutes the principle liquid source of nourishment in a progressively diversified diet for infants aged from six months.*

Toddler milk products fall under FSANZ Standard 2.9.3 (Formulated Meal Replacements and Formulated Supplementary Foods) and are not suitable for infants under 12 months of age. They are therefore outside the scope of the MAIF Agreement and are also not captured by the Australia New Zealand Food Standards Code's Standard 2.9.1 or 2.9.2 that regulate infant formula products and foods for infants.

There has been a suggestion that the MAIF agreement should include toddler supplementary milk products. Changing the MAIF agreement to include toddler milk products would reframe the whole notion of the MAIF agreement which was set up to monitor the marketing of the only alternative to breast milk i.e. infant formula. Unlike breast milk, toddler milk is not a whole food but a complementary food. As a supplementary food it cannot be an alternative to breast milk and does not compete with breast milk in any way.

The Benefits of Toddler Milk

By 12 months of age toddlers have been introduced to solids and are making the transition to an adult diet, which includes solids of different textures and a variety of beverages.

It is important that toddlers obtain a full complement of nutrients that are crucial to their development. Toddlers require 13 vitamins and at least 16 minerals to keep their bodies working properly. Toddlers are however prone to being picky or faddy eaters. As such, they may not consume adequate amounts of the key nutrients.

Almost all healthy toddlers get enough protein, fat and carbohydrate. The nutrients most likely to be low in toddlers' diets are calcium and iron. Toddlers may also be particularly vulnerable to zinc deficiency, especially those who are fussy eaters or have small appetites.

As well as solid foods, milk is an important food for toddlers and preschoolers, as it supplies protein, is an excellent source of calcium and riboflavin (Vitamin B2). It contributes also to the daily intake of other essential nutrients such as zinc and Vitamin A. Regular cow's milk is a poor source of iron, iodine and key vitamins including vitamin C and D. It contains only traces of iron and very little Vitamin C, which aids in the absorption of iron. Studies in numerous countries including Australia have reported a significant association between intake of cow's milk and iron deficiency anaemia in young childhood.¹

¹ Bramhagen et al 1999, Freeman et al 1999, Oti-Boateng et al 1998.

Specially formulated toddler milk is based on cow's milk and has the benefits of cow's milk with added calcium, iron, zinc and a range of essential nutrients including protein, minerals and vitamins, including C and D. Toddler milks provide an alternative to cow's milk, they are designed to supplement a toddler's diet and like cow's milk, it is recommended that toddler's consume a relatively small volume of no more than 2 cups per day.

Toddler milks are not intended to be the primary source of nutrition since toddlers usually consume the same mixed diet as the rest of the family. Solid foods are the major source of nutrition.

Iron, Vitamin D and Iodine Status of children in Australia and New Zealand

Iron intakes of very young children in Australia appear to be low. The National nutrition Survey 1995 showed that one in three 2-3 year olds had intakes below the recommended dietary intake and one in ten were below seventy percent of the RDI.²

According to the National Health and Medical Research Council "Dietary Guidelines for Children and Adolescents in Australia", pages 104-105...

"Studies of the extent of the problem of iron deficiency in children and adolescents in Australia have been done only on relatively small groups of children to date but the results suggest that significant numbers of children (up to 35%), particularly young children, may be iron depleted. Aboriginal children appear to be especially at risk."

Toddlers are particularly vulnerable to iron deficiency and its consequences. Iron deficiency and anaemia in young children is a significant global public health problem (WHO 2001). It is of local concern as well with one study reporting the incidence of iron deficiency or anaemia was about 35% amongst 12 to 24 month olds.³

A number of studies have been done about the effects of iron deficiencies in the development of young children (see References). Iron deficiency anaemia during infancy and young childhood can result in long-term deficits in cognitive and motor development that persists into childhood and adolescence.⁴ The effects of anaemia may be irreversible, as studies have shown that, even with hematologic correction, both motor and mental function remains lower amongst children who had been iron deficient as a toddler.⁵

Iron fortified nutritional beverages like toddler milks have been recommended to help prevent iron deficiency and anaemia in toddlers.⁶ Iron deficiency has been reported to be infrequent amongst children consuming these

² Dietary Guidelines for Children and Adolescents in Australia - NHMRC April 2003

³ Oti-Boatend 1998

⁴ Lozoff et al 1991, Lozoff et al 2000, Lozoff et al 2006

⁵ Lozoff et al 1991

⁶ Haschke 1999

beverages.⁷ Additionally, a study conducted in Australia has shown iron-fortified milks to be effective in treating iron deficiency anaemia in older infants and young toddlers.⁸

Vitamin D deficiency amongst toddlers is a growing concern in Australia and NZ.⁹ As cow's milk is not fortified with this important vitamin and it is not normally found in common foods, use of vitamin D fortified toddler milk may help prevent vitamin D deficiency.

Recent studies in Australia and New Zealand indicate that iodine deficiency in pregnant and breastfeeding women, and very young children, is relatively common.¹⁰ This is perhaps unsurprising, given that our soils are iodine poor and recommendations to reduce salt consumption have led to a decline in the domestic use of iodised salt.

Iodine deficiency and associated hypothyroidism can lead to impaired mental function. Iodine deficiency during early childhood is an issue in New Zealand and some areas in Australia (e.g. Tasmania).¹¹

Toddler milk is a great supplement for all children but it is particularly valuable as a supplementary food for children at risk of specific mineral deficiencies.

Breastfeeding Rates and Marketing of Toddler Milk

There is no research that IFMAA members are aware of that has been conducted into the marketing of toddler milk and its possible impact on breastfeeding rates. However research has indicated that there are multiple barriers that are preventing mothers from breastfeeding, none of which have related to infant formula marketing or information, or the advertising and marketing of toddler milks.

In fact ABS statistics show that breastfeeding rates have slightly increased during the period that toddler milk has been marketed. The fact that there has been an increase and not a decrease in breastfeeding rates indicates that toddler milk marketing is probably not impacting.

IFMAA believes that evidence based practice is the only reasonable basis for any public health campaign. Any anecdotal opinion that toddler milk marketing impacts on breastfeeding rates can simply be countered by anecdotal opinion that the marketing of toddler milk has no impact on breastfeeding rates.

The Marketing of Toddler Milk

IFMAA companies market toddler milk drink products as suitable for toddlers over 12 months of age. They are designed and marketed to be a complementary source of vitamins and minerals and other beneficial nutrients

⁷ Bramhagen et al 1999

⁸ Wall et al 2005

⁹ See Blok et al 2000, Robinson et al 2006

¹⁰ Skeaff 2006

¹¹ Skeaff et al 2005

for young children but they are not a complete food and are not designed to replace meals.

There are other products on the market for young children that are quite obviously not specially formulated as a nutritional alternative to cows' milk, for example, powdered milk products, flavoured milks, fruit juices and soft drinks.

If the marketing of one product consumed by some toddlers i.e. toddler milk were to be restricted and if IFMAA members were to voluntarily agree to such a limitation, as they do for infant formula, such an agreement would constitute an unfair trade restriction on toddler milk and a trade benefit to every other milk product that is consumed by children over 12 months such as nutrient fortified milk additions, flavoured milk and regular milk.

Even voluntary marketing constraints on manufacturers producing toddler supplementary milk products would require reporting from the Australian Government to the World Trade Organisation and permission from the Australian Competition and Consumer Commission (ACCC). It would be regarded as decreasing competition within the market place through an unfair trade restriction which is a breach of the Trade Practices Act 1974. Such draconian control cannot be supported either by evidence or logic.

If on the other hand, there was evidence that the marketing of toddler milk products affected breastfeeding rates adversely and it was proven that there was a genuine need to control the marketing of these products, then perhaps there should be a new voluntary agreement. To avoid unfair trade restrictions and any breach of the Trade Practices Act 1974 all milk products (and other beverages) that are consumed by toddlers would have to be included in this agreement. This would mean that all manufacturers of milk products that are consumed by children over 12 months including the dairy industry would have to agree to sign-off on the voluntary self-regulatory code and the compliance process.

Many companies marketing milk products for children over 12 months of age may decline the invitation to participate in a voluntary code, thereby creating an anti-competitive advantage for these companies over the IFMAA companies.

Anti competitive advantage goes against the ACCC and the Trade Practices Act 1974.

As there is no evidence that the marketing of toddler milk products adversely affects breastfeeding rates the debate remains an emotional and political one and has moved into the arena of regulated competition.

Restricting the marketing of toddler milk products is not necessary, not supported by the requirements of the WHO Code and would certainly not be supported by IFMAA.

Conclusion

Toddler milk products can play an important public health role in fulfilling the nutritional needs of young children when their diets are insufficient, particularly in the instance of iron deficiency. They can also be safely used by healthy toddlers to ensure that a variety of nutritional needs are met for optimal growth and health.

The purpose of the inquiry is to improve breastfeeding rates for infants in Australia and particularly to encourage and promote the practice of full breastfeeding for the first 6 months of life. Its purpose should not include restricting the marketing of products that are beneficial for some toddlers' development and which do not compete with breastfeeding.

IFMAA strongly supports efforts to increase breastfeeding rates. However, no studies have provided data that suggest that the marketing of toddler milk has negatively impacted on breastfeeding rates, past or present. The comparison is irrelevant since toddler milk is an alternative to cow's milk in children aged over 12 months, it is not a substitute for breast milk, infant formula or follow on formula and it does not compete with breast milk in any way.

Since there is no evidence that the production and marketing of toddler milk has any effect on breastfeeding rates there appears to be no logical argument for proposing an agreement to voluntarily restrict the marketing of toddler milk.

On the other hand, the anticompetitive nature of singling out toddler milk products which are not part of the WHO Code, for inclusion in any marketing restriction agreement would be a breach of the Trade Practices Act 1974 and would not likely be condoned by the ACCC or the World Trade Organisation.

The aim of the Australian Government is to increase breastfeeding rates. The real solution lies in addressing the identified evidenced based barriers that some mothers face rather than concentrating on a milk drink that is designed for children over 12 months of age.

10th May 2007

References

- Blok BH, Grant CC, McNeil AR, Reid IR. Characteristics of children with florid vitamin D deficient rickets in the Auckland region in 1998. *N Z Med J.* 2000;113:374-376.
- Bramhagen A-C, Axelsson I. Iron status in southern Sweden: effects of cow's milk and follow on formula. *Acta Paediatr.* 1999; 88:1333-1337.
- Freeman WE, Mulder J et al. A longitudinal study of iron status in children at 12, 24 and 36 months. *Public Health Nutrition* 1998; 1:93-100
- Dr. Cameron C Grant¹ FRACP PhD, Dr. Clare R. Wall² PhD, 18th August 2005 The relevance of iron deficiency as a child health issue in Australia and New Zealand today
- Haschke F. The rationale for iron-fortified follow-on formulas and growing-up milks. *Acta Paediatr.* 1999; 88:1312-1313.
- Lozoff B, Jimenez E, Wolf AW. Long-term developmental outcome of infants with iron deficiency. *N Engl J Med.* 1991; 325:687-694
- Lozoff B, Jimenez E, Hagen J, Mollen E, Wolf AW. Poorer behavioral and developmental outcome more than 10 years after treatment for iron deficiency in infancy. *Pediatrics* [serial online]. 2000; 105(4): e51. Available at: <http://www.pediatrics.org/cgi/content/full/105/4/e51>.
- Lozoff B, Jimenez E, Smith JB. Double Burden of Iron Deficiency in Infancy and Low Socioeconomic Status: A Longitudinal Analysis of Cognitive Test Scores to Age 19 Years. *Arch Pediatr Adolesc Med.* 2006; 160(11):1108-1113.
- Oti-Boateng P, Seshadri R et al. Iron status and dietary iron intake of 6-24 month-old children in Adelaide. *J Pediatr Child Health* 1998; 34:250-253.
- P D Robinson, W Ho"gler, M E Craig, C F Verge, J L Walker, A C Piper, H J Woodhead, C T Cowell, G R Ambler. The re-emerging burden of rickets: a decade of experience from Sydney. *Arch Dis Child* 2006; 91:564-568.
- Skeaff SA, Ferguson EL, McKenzie JE, Valeix P, Gibson RS, Thomson CD. Are breast-fed infants and toddlers in New Zealand at risk of iodine deficiency? *Nutrition.* 2005; 21(3): 325-331.
- Skeaff SA, Iodine deficiency in those most at risk: pregnant women and very young children. *Asia Pacific Journal of Clinical Nutrition* 2006; 15 (Suppl 3): S68
- Wall CR, Grant CC, Taua N, Wilson C, Thompson JMD. Milk versus medicine for the treatment of iron deficiency anaemia in hospitalized infants. *Arch Dis Child.* 2005; 90:1033-1038.
- World Health Organization, Iron deficiency anemia, Micronutrient deficiencies. <http://www.who.int/nutrition/topics/ida/en/index.html> Accessed April 25, 2007.

Appendix

Annex 3 of the WHO Code (Page 32)

“The scope of the draft code is defined in Article 2. During the first four to six months of life, breast milk alone is usually adequate to sustain the normal infant's nutritional requirements. Breast milk may be replaced (substituted for) during this period by bona fide breast-milk substitutes, including infant formula. Any other food, such as cow's milk, fruit juices, cereals, vegetables, or any other fluid, solid or semisolid food intended for infants and given after this initial period, can no longer be considered as a replacement for breast milk (or as its bona fide substitute). Such foods only complement breast milk or breast-milk substitutes, and are thus referred to in the draft code as complementary foods. They are also commonly called weaning foods or breast-milk supplements.

Products other than bona fide breast-milk substitutes, including infant formula are covered by the code only when they are "marketed or otherwise represented to be suitable...for use as a partial or total replacement of breastmilk". Thus the code's references to products used as partial or total replacements for breast milk are not intended to apply to complementary foods unless these foods are actually marketed - as breast-milk substitutes, including infant formula, are marketed - as being suitable for the partial or total replacement of breast milk. So long as the manufacturers and distributors of the products do not promote them as being suitable for use as partial or total replacements for breast milk, the code's provisions concerning limitations on advertising and other promotional activities do not apply to these products”.